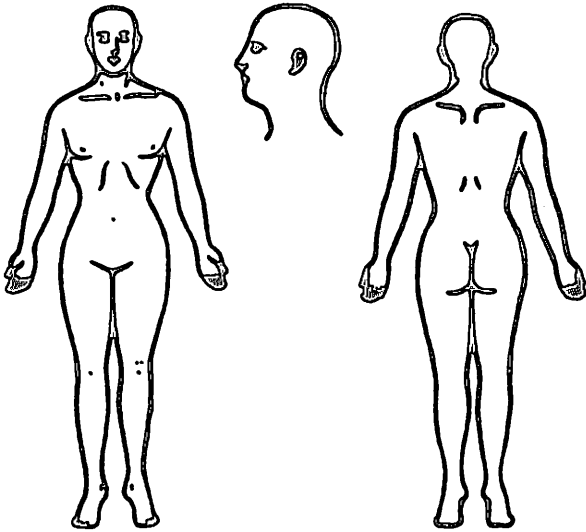


Date of Last Physical Examination _____

Please mark your areas of pain on the figures below.



Have you Ever Suffered From:

- 1. Dizziness _____
- 2. Backaches _____
- 3. Heart Trouble _____
- 4. Diabetes _____
- 5. Arthritis _____
- 6. Headaches _____
- 7. Asthma _____
- 8. Neuritis _____
- 9. Digestive Disorders _____
- 10. Nervousness _____
- 11. Sinus Trouble _____
- 12. Neck Pain _____

INSURANCE INFORMATION:

Is your condition due to an auto accident or job related injury? _____ Yes _____ No

Do you have Health Insurance? _____ Yes _____ No If yes,

Name of Company _____ Policy # _____

Are you covered by Medicare? _____ Yes _____ No

If yes, Health Insurance # _____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I will be paying today by Cash Check Credit Card

MasterCard Visa American Express Card # _____ Exp. Date _____

All accounts not paid within 90 days will *automatically* be put through on your credit card.

Patient's Signature: _____ Date _____

Guardian or Spouse's Signature: _____ S.S. # _____

Doctor's Signature: _____

FAMILY HEALTH INFORMATION. (Many health problems are the result of hereditary spinal weaknesses; thus information about your family members will give us a better picture of your total health picture.)

NAME	RELATION	PAST AND PRESENT HEALTH PROBLEMS